

**Conduct Disorder:
Treatment Recommendations
For Vermont Youth**

**From the
State Interagency Team**

By

Bill McMains, Medical Director, Vermont DDMHS
Alice Maynard, Mental Health Quality Management Chief, Vermont DDMHS
Lisa Conlan, Executive Director, Vermont Federation of Families for Children's Mental Health

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Purpose of this document

In the past year, the members of Vermont's State Interagency Team have been asked to provide technical assistance to several Local Interagency Teams (LITs) that were struggling with a common issue. The LITs were trying to help Treatment Teams develop and implement effective Coordinated Service Plans for youth with a diagnosis of "conduct disorder." Questions and confusion mainly occurred around the following points.

- What exactly does "conduct disorder" mean?
- What are the best practices for treatment to assure optimal outcomes for youth with conduct disorder? What evidence supports the claims to best practices?
- Do we have service providers who can readily pull together the services needed in the configuration needed?
- Who is responsible for pulling the plan together?
- Who is responsible for paying for the various components of the plan?

The members of the State Interagency Team decided to issue this short white paper on treatment for youth with a diagnosis of conduct disorder to avoid unnecessary confusion in the treatment planning process, to improve outcomes for youth, and to suggest direction for future development of the system of care.

What does “conduct disorder” mean?

Conduct Disorder is a description of behaviors that tend to cluster together. The essential underlying feature of these behaviors is a *repetitive* and *persistent* pattern of behaviors in which the basic rights of others are violated, or *major* age-appropriate societal norms or rules are violated. One time or short duration behaviors do not fit this category; neither do persistent violations of minor rules or norms.

The behaviors fall into four main groupings:

- 1) aggressive behaviors that cause or threaten physical harm to other people or animals,
- 2) non-aggressive behaviors that cause property loss or damage,
- 3) deceitfulness or theft, and
- 4) violation of major rules.

The *DSM-IV*, the diagnostic manual of the American Psychiatric Association, lists specific examples under each of these headings and requires three of these examples in the past 12 months and at least one in the past six months to apply the term to a particular child.

The *DSM-IV* further subdivides conduct disorder into subtypes by age of onset:

- 1) childhood onset if any one behavior occurs prior to age 10;
- 2) adolescent onset if no behaviors are seen prior to age 10; and
- 3) unspecified if it is unknown if there were any of the behaviors before 10.

This sub typing does help with prognosis since in general the earlier the age of onset, the worse the prognosis. The DSM also allows indication of severity into mild, moderate or severe.

It is important to point out that conduct disorder is not a diagnosis but a descriptor of a cluster of behaviors. It is not uncommon for people to use the term as if it is a diagnosis with implications that are not relevant. A diagnosis should communicate at least four types of information:

- 1) presentation, or how it looks now,
- 2) etiology, or cause,
- 3) prognosis, or how it will unfold over time, and
- 4) treatment guidelines.

Conduct disorder as we currently use the term does none of these things. Even in the category of current presentation both a child presenting with chronic truancy, running away and staying out late at night and a child who rapes, injures others and uses weapons in criminal activity fit the criteria. It is clear that these are two very different types of behaviors and it is inappropriate to assume these youngsters somehow cluster together. As we look at the other conditions for diagnosis, they also do not apply. There are multiple causes for these behaviors, the course is highly variable, and treatments will vary considerably depending on many other characteristics of the youth than the observed behaviors. The bottom line is that, when the term “conduct disorder” is used, no more information is imparted than if we were to say the youngster is behaving badly. Use of the term runs all the risks of labeling, which moves us to think stereotypically of people,

and none of the benefits of diagnosis, which can communicate an enormous amount of information in brief form.

Additional facts

According to the American Academy of Child and Adolescent Psychiatry, the prevalence is between 1.5% and 3.4% of the child population. The ratio of boys to girls is 5:1, but the difference decreases with advancing age. Childhood onset of conduct disorder has a greater frequency of neuropsychiatric disorders, low IQ, attention deficit hyperactive disorder, aggression and familial clustering of externalizing disorders than later onset. Other significant (but not diagnostic) features commonly seen with conduct disorder include lack of empathy, misperception of other's intent, lack of guilt or remorse, and low self-esteem. Suicidal ideation and attempts are much more common than with the general population and can exceed those for youth with depression. Some youngsters with conduct disorders present as over-restrained, with generally good impulse control, consideration of others, responsibility and suppression of aggression. They represent 38% of incarcerated delinquents and commit fewer but more violent crimes against people. They display a marked inability to attend to emotional states and elaborate mental states, especially when negatively charged.

There are a host of risk factors associated with conduct disorder. Some examples include genetic vulnerability, exposure to toxic substances early in life, physical damage to brain structures, altered brain functioning from unknown causes, family involvement in disruptive behaviors, temperament, attachment disruptions, maternal exposure to tobacco during pregnancy, negative effects of parenting, child abuse, and peer relationships. While no single risk factor in and of itself predicts conduct disorder, there is a higher likelihood as risk factors accumulate. Specific parenting skills can exert a positive effect and increase a child's resiliency. In general, if untreated, there will be a steady worsening through young adulthood and then a decline in virulence. Approximately 40% of conduct disordered youth continue on to have adult antisocial disorders. It should be noted that a majority of kids with conduct disorder do not go on with psychopathology in adulthood.

What does research tell us about best practices for treatment?

It is common with conduct disorders that there are multiple problems and co-morbidities. It is also well demonstrated that addressing one of the problems successfully is unlikely to impact the other problem areas. Each difficult area must be specifically identified and addressed if there is to be any expectation that that area will improve.

Therefore, it is essential to conduct a thorough assessment of all major potential problem areas as well as strengths and protective factors in order to plan an intervention for each one. Some of the common co-morbid conditions include ADHD, ODD, mood/anxiety disorders, PTSD, head trauma and seizures, and substance abuse. Assessments should include multiple informants since it is not uncommon for children to remember their histories differently than those around them. It is important to identify kids with transient behaviors from those with entrenched behaviors. Each underlying or co-occurring condition needs to be identified and interventions planned.

Each major domain should be identified and targeted with interventions. Some of the domains to be addressed would include:

- supervision and behavioral management needs;
- history of sexual and physical abuse;
- separation, divorce or death of key attachment figures;
- evidence of attachment capacity;
- educational potential, disabilities, achievements and learning style;
- peer relationships, especially the extent peers are reinforcing negative behaviors;
- family problems and strengths;
- environmental factors including disorganized home and lack of supervision;
- presence of neurotoxins such as lead; and
- ability to form and maintain relationships.

Interventions need to be applied over long periods of time. One of the major reasons for treatment failures is the application of the right treatment for too short a time. It is now clear from the research literature that boot camps, shock incarceration, isolated medication trials, psychiatric hospitalization, and cognitive behavioral interventions that are limited in number of sessions are all ineffective at best and can be injurious.

Effective interventions for conduct disorders in pre-school age children include Head Start programs, dealing with temperament and goodness of fit, and parental effectiveness. Medications have not been shown to be effective in this age group.

In school age children, effective interventions include parenting skills training, training the child in peer relationship skill, academic skill development, and social skills training. Pro-social skills and anti-social behaviors need to be addressed separately. Problem solving skill training is also effective in decreasing conduct disordered behaviors. Individual psychodynamic psychotherapy is not effective.

To date for adolescents the most promising approach has been Multi-systemic Therapy (MST) for violent conduct disorders. Cognitive behavioral approaches and skill training are still being studied, but there is cause for some optimism in these approaches.

For both school age children and adolescents, medications should be given as indicated for co-morbid conditions and to manage aggression according to the guidelines published in the Journal of the American Academy of Child and Adolescent Psychiatry, vol. 42, no. 2, February 2003.

Recommended guidelines for Treatment Teams

1. Conduct a thorough assessment using multiple informants to identify all significant problems (*e.g.*, delinquent behaviors, substance abuse, learning disability, reading difficulties).
2. Identify strengths and resiliency factors of the youth, family, and community on which to build successful strategies.
3. Identify each problem domain and plan specific interventions for **all** of them.
4. Be prepared to maintain interventions for a long period of time.
5. The Treatment Team should be sufficiently broad-based to cover the range of needed skills, services, funding, and supports. This should include members from the domain of public safety (*e.g.*, juvenile justice, police).
6. The Coordinated Service Plan
 - will need to include supervision and monitoring as part of the public safety component. Who provides and pays for it in the home, school, and community may vary by child and situation.
 - should include cognitive behavioral therapy, but not individual psycho-dynamic psychotherapy; and
 - should be designed to change and demonstrate progress over an extended period of time.
7. Families are important members of the successful Treatment Team; it is critical to assign them a realistic role for this type of situation. If the child is young, refining parenting skills through training can be beneficial. If the child is an adolescent, the family will need to share the responsibilities for supervision and monitoring with other team members, especially members from the public safety domain.
8. Remember that the vast majority of youth with these types of problems do not carry them into adult life, and these issues exist along a spectrum, with most youth in the mild to moderate range and amenable to treatment.